August 5, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1535-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a 34-year-old gentleman, injured his low back while installing rebar on ___. He noted pain in his low back with radiation down into the back of his left hip and on down the left leg. He also noted numbness and tingling in his leg, along with weakness. There was no history of previous back problems or previous injury to his lower back. He was treated conservatively with medication, physical therapy and limited activities; he did not improve. The pain continued and he was not able to return to work. A designated doctor saw him on July 15, 2002 and this designated doctor stated that he was not at MMI and he did not give him an impairment rating. The patient's pain continued. After a year, the symptoms were exactly the same. He had intractable pain down the left leg with inability to return to work. He was referred to ___ who is a spine surgeon. He felt that he was a candidate for surgery because of the lack of improvement after one year. The patient was worked up and had a CT myelogram on 8/7/02. This CT myelogram demonstrated narrowing of the spinal canal and disc bulging and ligamentous hypertrophy at the L4/5 level. In addition, he had narrowing of the spinal canal with central disc protrusion at L5/S1. There was also a grade 1 spondylolisthesis with a bilateral pars interarticularis defect. ___ examined the patient and he found that he still had a weakness in the left extensor hallucis longus and he was still having pain down the let. He felt that after a year he was certainly a candidate for surgery, which was to be laminectomy and fusion at the L5/S1 level.

___ saw the patient for a second opinion on September 18, 2002 and recommended weight reduction, aggressive physical therapy and exercise.

REQUESTED SERVICE

Spinal fusion and post lumbar decompression is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the records provided for review support the need for surgical treatment on this man's back. He has a grade 1 spondylolisthesis with persistent low back and left leg pain and weakness of the left extensor hallucis longus. This has been going on for over a year since the date of the original injury. The reviewer finds that the records support the need for this type of surgery and that this patient would be improved by a spinal fusion and decompression procedure.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 5th day of August 2003.